Cook Children’s Pain Management

1500 Cooper St.

Fort Worth, TX. 76104

682-885-7246

Patient History Form

Date of first appointment \_\_\_\_/\_\_\_/\_\_\_\_ Time of appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 Last First Middle

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Sex: F / M

 Street Apt #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: Home (\_\_\_)\_\_\_\_\_\_\_\_\_\_

 City State ZIP Work (\_\_\_)\_\_\_\_\_\_\_\_\_\_

The name of your Child’s primary care physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date when pain first began (approximate):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In What part of the body did the pain begin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Under what circumstances did the pain begin: (please circle)

 Accident Following surgery Following Illness Pain just began

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe the circumstance(s) you circled. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe briefly your child’s present symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe pain (circle all that apply)

Aching Pressure Stabbing Burning Prickling Throbbing

Dull Sharp Tingling Numbness Shooting

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle what makes pain better:

Heat Ice Rest Lying down Weather/Temperature changes

Standing Sitting Medications Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle what makes pain worse:

Walking Lifting Bending Lying down Weather/Temperature changes

Standing Sitting Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate pain intensity on a scale from 0 = no pain to 10 = pain that requires a visit to the ER

Pain on an average day:

0 1 2 3 4 5 6 7 8 9 10

Most intensity pain has reached

0 1 2 3 4 5 6 7 8 9 10

Least intensity of pain

0 1 2 3 4 5 6 7 8 9 10

Prior Treatments (circle all that apply) Helpful Not Helpful

Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_

Nerve Block \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_

TENS \_\_\_ \_\_\_

Physical Therapy \_\_\_ \_\_\_

Occupational Therapy \_\_\_ \_\_\_

Biofeedback/Relaxation Therapy \_\_\_ \_\_\_

Chiropractic Manipulation \_\_\_ \_\_\_

Psychology/psychiatry \_\_\_ \_\_\_

Medical Acupunture \_\_\_ \_\_\_

Massage \_\_\_ \_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_

Surgeries Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physicians your child has seen for this problem

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone number Fax number

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Name Phone number Fax number

Any serious injuries? no yes if yes please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious Illnesses? no yes if yes please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child received any diagnostic tests for this pain problem: exp: MRI, X-ray, CT, Labs, etc.

If other than Cook Children’s

 Test Done Month/year Facility

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Does your child have difficulty with?

Speaking Yes No

Vision Yes No

Hearing Yes No

If yes please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have developmental delays? If yes please describe.

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Does pain disrupt sleep?

How long does it take for your child to fall asleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does pain wake your child from sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time does your child go to sleep and what time do they wake in the morning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child drink caffeinated beverages? (Tea, soda, coffee, etc.) if yes cups/glasses per day? \_\_\_

Activities that your child is involved with. Please circle.

Sport – if yes, which sport \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dance – if yes, type of dance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Band – if yes, which instrument\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gymnastic

FFA

Other – Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours a week does your child participate in this activity including practice time? \_\_\_\_\_\_\_\_\_\_

School

Does your child attend school? No Yes

Grade level\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your Child miss school due to pain? No Yes If yes how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does pain keep your child from activities that they would like to participate in? If yes, please explain

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What type of impact does your child’s pain have on the family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your expectations from the pain management team? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE LIST ALL MEDICATIONS**

Include over-the-counter medications

|  |  |  |  |
| --- | --- | --- | --- |
| CURRENT MEDICATIONS | DOSAGE | FREQUENCY | PLEASE CHECK: HELPED? A Lot Some Not At All |
|  |  |  |  |  |  |
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How many times a week does your child take over the counter medications for pain such as Tylenol, Ibuprofen, Motrin, etc.

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Please list any/all medications your child has tried for their pain. (Example: Gabapentin (Neurontin), Amitriptyline (Elavil). Non-Steroidal Anti-inflammatories, Narcotics, Muscle Relaxants, Lyrica, Celebrex, etc.:

|  |  |
| --- | --- |
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

Medication Allergies? If yes, please list name of medication and reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please mark the location(s)

 of your pain on the diagrams

 with an “x”. If whole areas

 are painful, please shade in

 the painful area.

Are you: 􀂅 Right Handed

 􀂅 Left Handed

 

R L L R

  

 Right Left